Complete Summary

GUIDELINE TITLE

HIV prophylaxis following non-occupational exposure including sexual assault.

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. HIV prophylaxis following non-occupational exposure including sexual assault. New York (NY): New York State Department of Health; 2008 Jan. 35 p. [31 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: New York State Department of Health. HIV prophylaxis following non-occupational exposure including sexual assault. New York (NY): New York State Department of Health; 2005 Dec. 46 p.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Human immunodeficiency virus (HIV) infection
- Hepatitis B virus (HBV) infection
- Hepatitis C virus (HCV) infection

GUIDELINE CATEGORY

Counseling
Evaluation
Management

Prevention
Risk Assessment

CLINICAL SPECIALTY

Allergy and Immunology
Family Practice
Infectious Diseases
Internal Medicine
Obstetrics and Gynecology
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Nurses
Physician Assistants
Physicians
Social Workers

GUIDELINE OBJECTIVE(S)

To provide recommendations and guidelines for prescribing post-exposure prophylaxis (PEP) following non-occupational exposure to human immunodeficiency virus (HIV) including sexual assault

TARGET POPULATION

Individuals with non-occupational exposure to human immunodeficiency virus (HIV) including sexual assault, needle-sharing activities, needlesticks outside of occupational settings, and trauma such as human bites

INTERVENTIONS AND PRACTICES CONSIDERED

Risk Assessment/Evaluation/Counseling

1. Risk assessment to determine whether non-occupational post exposure prophylaxis (nPEP) is indicated including risk behavior, type of exposure, human immunodeficiency virus (HIV) status of the alleged assailant for victims of sexual assault
2. Baseline testing including HIV testing, assessment for other sexually transmitted diseases (STDs), pregnancy test
3. Counseling regarding the initiation of nPEP
4. Discussing the role of rape crisis counselor and sexual assault forensic examiner with victims of sexual assault
5. Counseling regarding fetal benefits and risks of antiretroviral (ARV) therapy with pregnant women
6. Sequential confidential HIV testing at 1, 3, and 6 months post-exposure

Management/Prevention

1. Timely initiation of three-drug ARV therapy: zidovudine and lamivudine (or co-formulated as Combivir) plus tenofovir. Alternative treatment: zidovudine plus emtricitabine + tenofovir
2. Close monitoring of patients to detect ARV-induced toxicities
3. Administration of hepatitis B immune globulin (HBIG) and initiation of hepatitis B vaccine series
4. Obtaining baseline hepatitis C virus (HCV) serology, serum alanine aminotransferase (ALT), HCV antibody and qualitative HCV viral load (HCV ribonucleic acid polymerase chain reaction [RNA PCR])
5. Referral to clinician with experience in treating HCV

MAJOR OUTCOMES CONSIDERED

Effectiveness of post-exposure prophylaxis

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

AIDS Institute clinical guidelines are developed by distinguished committees of clinicians and others with extensive experience providing care to people with HIV infection. Committees* meet regularly to assess current recommendations and to write and update guidelines in accordance with newly emerging clinical and research developments.

The Committees* rely on evidence to the extent possible in formulating recommendations. When data from randomized clinical trials are not available, Committees rely on developing guidelines based on consensus, balancing the use of new information with sound clinical judgment that results in recommendations that are in the best interest of patients.

Because there are no randomized, placebo-controlled experimental clinical trials on which to definitively base recommendations, these guidelines for non-occupational post exposure prophylaxis (nPEP) are based on best practice evidence and constitute the considered opinion of the group of expert clinicians in the field of adult HIV medicine who comprise the Medical Care Criteria Committee.

To develop these guidelines for nPEP, the group of clinicians and scientists serving on the Medical Care Criteria Committee reviewed the medical literature as well as existing recommendations and guidelines from government and community sources. They also considered specific concerns related to the process of implementing nPEP. Throughout the discussions of the Committee, a conscious effort was made to weigh both the medical and psychological benefits and risks of medical intervention in the context of a potential HIV exposure.

The Committee addressed the following questions:

- Under what circumstances would individuals at risk for HIV infection benefit from nPEP?
- What settings and program service components allow for the most effective delivery of nPEP?
- What is the appropriate timing for initiation of nPEP? Is there a time after which prophylaxis would not be indicated or advisable?
- Which drugs should be used for nPEP?
- For how long should nPEP be continued?
- What constitutes appropriate monitoring and follow-up?
- What are the cost considerations?

* Current committees include:

- Medical Care Criteria Committee
- Committee for the Care of Children and Adolescents with HIV Infection
- Dental Standards of Care Committee
- Mental Health Committee
- Women's Health Committee

- Substance Use Committee
- Physician's Prevention Advisory Committee
- Pharmacy Committee

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

The guideline developers reviewed published cost analyses.

Cost-effectiveness analyses have suggested that non-occupational post-exposure prophylaxis (nPEP) is cost-effective in high-risk exposures such as receptive anal sex with a human immunodeficiency virus (HIV)-infected partner or a partner of unknown HIV status.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

All guidelines developed by the Committee are externally peer reviewed by at least two experts in that particular area of patient care, which ensures depth and quality of the guidelines.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

PEP Following Non-Occupational Exposures (nPEP)

Assessment to Determine Whether nPEP is Indicated

Whenever possible, risk assessment and initiation of nPEP should occur in clinical settings where human immunodeficiency virus (HIV) prevention counseling services, as well as HIV clinical expertise, are available or are easily accessed by referral.

Patients who present for nPEP should be evaluated as soon as possible in order to initiate therapy, if indicated, within recommended time frames (see "Timing of Initiation of PEP for All Non-Occupational Exposures" below).

When deciding whether to recommend the initiation of nPEP, the clinician should assess and carefully weigh the following factors (see the table "Elements of Assessment to Determine whether nPEP Is Indicated" below):

- The behavioral factors and circumstances that led to HIV exposure

- The patient's risk of HIV acquisition based on the type of exposure
- The possibility that the source is HIV-infected

The clinician should provide risk-reduction counseling and primary prevention counseling whenever someone is assessed for nPEP, regardless of whether PEP is initiated.

Non-occupational PEP should not be prescribed when there is negligible or low risk of HIV transmission (see the table "Consideration of nPEP According to the Type of Risk Exposure" below).

Non-occupational PEP should not be used as a pre-exposure prophylactic measure to prevent HIV transmission in a woman wishing to become pregnant with an HIV-infected male partner, or as prophylaxis for any person who plans to engage in high-risk behavior.

Clinicians should provide supportive counseling and make referrals for counseling for patients for whom nPEP is not prescribed.

Table
Elements of Assessment to Determine Whether nPEP is Indicated

Risk Behavior:

- Did exposure to potentially HIV-infected blood or body fluid occur?
- Was the exposure an isolated or episodic event, or result of habitual behavior?

Degree of Transmission Risk Based on Type of Exposure:

- What was the route of exposure?
- Are factors present that are known to further increase transmission risk?

Exposure Source:

- Is the source known to be HIV-infected?*
- If HIV status of the source is unknown, what is the likelihood of the source being HIV infected (see Table 4 in the original guideline document)?

*If the source is known to be HIV infected, information about his/her CD4 count, viral load, antiretroviral (ARV) medication history, and history of ARV drug resistance should be obtained when possible to assist in selection of a PEP regimen.

Table
Consideration of nPEP According to the Type of Risk Exposure

Types of Exposures That Do Not Warrant nPEP	Types of Exposures That Should Prompt Consideration of nPEP

• Kissing • Oral-to-oral contact without mucosal damage (mouth-to-mouth resuscitation) • Human bites not involving blood • Exposure to needles or sharps not in contact with an HIV-infected or at-risk person • Mutual masturbation without skin breakdown • Oral-anal contact • Receptive penile-oral contact without ejaculation • Insertive penile-oral contact • Oral-vaginal contact without blood exposure	• Unprotected receptive and insertive vaginal or anal intercourse with a source that is HIV-infected or at risk for HIV infection • Unprotected receptive penile-oral contact with ejaculation with a source that is HIV-infected or at risk for HIV infection • Oral-vaginal contact with blood exposure • Needle sharing with a source known to be HIV-infected or at risk for HIV infection • Injuries with exposure to blood from a source known to be HIV-infected or at risk for HIV infection (including needlesticks, human bites, accidents)

Baseline Testing for Patients Who Present with Risk Exposures

The clinician should perform baseline HIV testing of the exposed person. Initiation of nPEP should not be delayed pending HIV test results. Where available, rapid testing should be used.

The clinician should perform an assessment for other sexually transmitted diseases (STDs), such as chlamydia, gonorrhea, and syphilis, and should provide STD prophylaxis in sexually exposed patients.

The clinician should obtain baseline pregnancy testing for exposed women. Emergency contraception should be offered to and discussed with women at risk of pregnancy from the exposure.

Deciding to Recommend nPEP

The clinician should initiate nPEP ideally within 2 hours and generally no later than 36 hours following exposure when an isolated exposure (sexual, needle, or trauma) has occurred or when risk-reduction practices fail.

The clinician should discuss the following issues with the patient and should document that they were discussed before initiating a regimen:

- The potential benefit, unproven efficacy, and potential toxicity of nPEP
- The need for adherence
- The need to initiate/resume risk-reduction and preventive behaviors
- Signs and symptoms of primary HIV infection
- The need for clinical and laboratory monitoring and follow-up

The patient should agree to follow-up monitoring and initiation of interventions to reduce risk, if applicable, before the clinician initiates nPEP. All components of this discussion should be documented so that events leading to infection can be clearly identified and the efficacy of nPEP can be assessed.

Behavioral Intervention and Risk-Reduction Counseling

Behavioral intervention for risk reduction should occur regardless of whether nPEP is initiated or not.

Clinicians should assess for emotional, psychological, and social factors that can contribute to risk behavior, such as depression, history of sexual abuse, and drug and alcohol use.

Clinicians should refer patients to mental health and/or substance use programs when indicated and should consider the need for intensive risk-reduction counseling services.

PEP for Sexual Assault Survivors

Survivors of sexual assault should be treated in an emergency department or equivalent healthcare setting where all appropriate medical resources are available as needed.

Assessment to Determine Whether nPEP Is Indicated Following Sexual Assault

When deciding whether to recommend the initiation of nPEP following sexual assault, the clinician should assess and carefully weigh the following factors:

- Whether or not a significant exposure has occurred during the assault
- Knowledge of the HIV status of the alleged assailant
- Whether the survivor is ready and willing to complete the nPEP regimen

The clinician's decision to recommend nPEP should not be influenced by the geographic location of the assault.

Degree of Risk Based on Type of Exposure

Clinicians should recommend HIV nPEP to survivors when significant exposure may have occurred, as defined by direct contact of the vagina, anus, or mouth with the semen or blood of the alleged assailant, with or without physical injury, tissue damage, or presence of blood at the site of the assault.

Non-occupational PEP should also be offered in cases when broken skin or mucous membranes of the survivor have been in contact with blood or semen of the alleged assailant. Similarly, nPEP should be offered in cases of bites that result in visible blood.

Considering the HIV Status of the Alleged Assailant

Unless the identity and HIV status of the alleged assailant has been clearly established to assist with the decision-making, nPEP should be promptly initiated when a significant risk exposure has occurred.

Even when the alleged assailant is known to be HIV infected, the decision to recommend nPEP should be based on the nature of the exposure and the survivor's ability to complete the regimen.

If prophylaxis has been initiated and the alleged assailant is found to be HIV-antibody negative, then nPEP should be discontinued.

Recommending nPEP for Sexual Assault Survivors

Non-occupational PEP should be initiated as soon as possible after exposure. Non-occupational PEP is unlikely to be effective more than 36 hours post-exposure (see "Timing of Initiation of PEP for All Non-Occupational Exposures" below).

Starter packs of medication should be available on-site for rapid initiation of nPEP following sexual assault. Arrangements should be made to ensure that the patient receives a continued supply of medication and is referred to an HIV Specialist.

The recommendation for nPEP should be communicated simply and clearly to the patient, considering his/her emotional state and ability to comprehend the nature of ARV treatment.

If a sexual assault survivor is too distraught to engage in a discussion about the drug regimen or make a decision about whether to initiate treatment at the initial assessment, the clinician should offer a first dose of medication and make arrangements for a follow-up appointment within 24 hours to further discuss the indications for nPEP.

If a sexual assault survivor decides to initiate treatment, a follow-up visit should be scheduled within 24 hours to review the decision, evaluate initial drug tolerability, reinforce the need for adherence to the regimen, and arrange for follow-up care.

The discussion regarding initiation of nPEP should include the following:

- The potential to prevent HIV infection
- Possible side effects of the nPEP regimen
- Duration of nPEP and the monitoring schedule
- Importance of adherence to the treatment regimen to prevent nPEP failure or the development of drug resistance should infection occur

The Role of the Rape Crisis Counselor and Sexual Assault Examiner

The rape crisis counselor should be an active participant in the discussion regarding HIV nPEP.

The plan for follow-up care should be discussed with the rape crisis counselor or an outreach worker who will be working with the survivor following the survivor's departure from the emergency department or equivalent healthcare setting.

HIV Testing of the Survivor

Clinicians should obtain blood for baseline HIV serologic testing when recommending initiation of nPEP. Prophylaxis, when indicated, should be started without waiting for the results of this test.

Refusal to undergo baseline testing should not preclude initiation of nPEP.

Timing of Initiation of PEP for All Non-Occupational Exposures

Non-occupational PEP should be offered as soon as possible after exposure and initiated ideally within 2 hours and no later than 36 hours following exposure. Non-occupational PEP is unlikely to be effective more than 36 hours post-exposure.

Recommended nPEP Regimens

Clinicians should initiate three-drug ARV therapy for significant exposures to HIV. The preferred nPEP regimen is: zidovudine 300 mg orally (po) twice a day (bid) + lamivudine 150 mg po bid (or Combivir 1 po bid) plus tenofovir 300 mg po every day (qd) or Zidovudine 300 mg PO bid plus Emtricitabine 200 mg PO qd + Tenofovir 300 mg PO qd (or Truvada 1 PO qd). Alternative agents may be used in the setting of drug intolerance or toxicity (see Table 5 and Appendix A in the original guideline document).

When the source is known to be HIV infected and information regarding previous ARV therapy, current level of viral suppression, or genotypic/phenotypic resistance profile is available, the clinician, in consultation with an HIV Specialist, should individualize the regimen to more effectively suppress viral replication.

The nPEP regimen should be continued for 4 weeks.

Monitoring Following Non-Occupational Exposure Including Sexual Assault

Clinicians should closely monitor people receiving nPEP to detect ARV-induced toxicities.

Because of the complexity and potential adverse effects of the nPEP regimens, longitudinal care of the exposed patient should be provided either directly by or in consultation with an HIV Specialist.

Sequential confidential HIV testing should be obtained at baseline, 1, 3, and 6 months post-exposure even if nPEP is declined (see Table 6 in the original guideline document). In New York State, if the test result is positive, a Western blot assay must be performed to confirm the diagnosis of HIV infection.

Any acute febrile illness post-exposure accompanied by one or more of the following -- rash, lymphadenopathy, myalgias, sore throat -- suggests the possibility of acute HIV seroconversion and requires urgent evaluation. If the patient presents with signs or symptoms of acute HIV seroconversion, immediate consultation with an HIV Specialist should be sought for optimal diagnostic testing and treatment options.

Non-Occupational PEP for the Pregnant Patient

Before administering nPEP to a pregnant woman, the clinician should discuss the potential benefits and risks to her and to the fetus. Drugs to avoid during pregnancy are: efavirenz, combination of stavudine and didanosine, and unboosted indinavir (IDV) in the second and third trimester.

Based on increasing clinical experience with highly active antiretroviral therapy (HAART), nPEP is indicated at any time during pregnancy when a significant exposure has occurred, despite possible risk to the woman and the fetus. Expert consultation should be sought. When nPEP is indicated, it should be initiated within 36 hours of exposure.

Clinicians should not prescribe efavirenz for pregnant women because it has been associated with teratogenicity in monkeys.

Clinicians should not prescribe the combination of didanosine and stavudine due to an increased risk of mitochondrial toxicity in pregnant women.

Unboosted indinavir should not be used in pregnant women in the second or third trimester due to a substantial decrease in antepartum indinavir plasma concentrations.

Clinicians should advise women who may have been exposed to HIV to avoid breastfeeding for 6 months after the exposure.

Non-Occupational PEP for Hepatitis B and C

The hepatitis B vaccine series should be initiated in non-hepatitis B virus (HBV)-immune patients who sustain a blood or body fluid exposure.

Administration of prophylactic hepatitis B immune globulin (HBIG) and the initiation of the hepatitis B vaccine series (at different sites) are recommended when the non-HBV-immune patient sustains a blood or body fluid exposure to a source with known acute or active HBV (see table "Recommended Post-Exposure Prophylaxis for Non-Occupational Exposure to Hepatitis B Virus" below).

If the source is known to be hepatitis C virus (HCV)-antibody positive or if the serostatus is unknown, baseline HCV serology and serum alanine aminotransferase (ALT) should be obtained from the exposed patient and should be repeated at 4 to 6 months post-exposure.

If the source is known to be HCV-antibody positive, an HCV antibody and qualitative HCV viral load (HCV ribonucleic acid polymerase chain reaction [RNA PCR]) should be obtained from the exposed patient 4 weeks after exposure.

In the setting of an acute elevation of ALT in the exposed patient in the first 24 weeks post-exposure, a qualitative HCV RNA PCR should be obtained.

When HCV infection is identified, the exposed patient should be referred for medical management to a clinician with experience in treating HCV.

Table
Recommended Post-Exposure Prophylaxis for Non-Occupational Exposure to Hepatitis B Virus

Vaccination and/or Antibody Response Status of Exposed Patient*	Treatment When Source Is:		
	HBsAg Positive	HBsAg Negative	Source Unknown or Not Available for Testing
Unvaccinated/non-immune	HBIG** x1; initiate HB vaccine series	Initiate HB vaccine series	Initiate HB vaccine series
Previously vaccinated, known responder***	No treatment	No treatment	No treatment
Previously vaccinated, known non-responder***	HBIG** x2 or HBIG** x1 and initiate revaccination[#]	No treatment	If known high-risk source, treat as if source were HBsAg positive
Previously vaccinated, antibody response unknown	Test exposed person for anti-HBs: • If adequate***, no treatment • If inadequate***, HBIG x1 and vaccine booster	No treatment	Test exposed person for anti-HBs: • If adequate***, no treatment • If inadequate***, initiate revaccination

Reprinted from the Updated US Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Post-Exposure Prophylaxis. *MMWR Morb Mortal Wkly* Rep 2001;50(RR-11):1-42. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm.

HBsAg, hepatitis B surface antigen; HBIG, hepatitis B immune globulin; anti-HBs, antibody to hepatitis B surface antigen.

*Persons who have previously been infected with HBV are immune to re-infection and do not require PEP.
** Dose 0.06 mL/kg intramuscularly.
*** Responder is defined as person with adequate levels of serum antibody to HBsAg (serum anti-HBs ≥10mIU/mL); non-responder is a person with inadequate response to vaccination (serum anti HBs <10mIU/mL).
# The option of giving one dose HBIG and re-initiating the vaccine series is preferred for non-responders who have not completed a second 3-dose vaccine series. For persons who previously completed a second vaccine series but failed to respond, two doses of HBIG are preferred.

CLINICAL ALGORITHM(S)

An algorithm is provided in the original guideline document for "Post-Exposure Prophylaxis (PEP) Following Non-Occupational Exposure Including Sexual Assault."

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Effective management of non-occupational post-exposure prophylaxis (nPEP) for human immunodeficiency virus (HIV) and hepatitis B and C virus
- Reduction in risk of transmission of HIV, hepatitis B virus (HBV), and hepatitis C virus (HCV) after non-occupational exposure including sexual assault

POTENTIAL HARMS

- Medications used for non-occupational post-exposure prophylaxis have risks of toxicity. Please refer to Appendix A of the original guideline document for information on toxicity, dose adjustments, and use in pregnancy for specific antiretroviral (ARV) drugs.
- Although birth defects and adverse effects on human fetuses have generally not been associated with the currently available ARV agents, exposure of a fetus to ARV agents during pregnancy carries a theoretical risk of teratogenicity.

CONTRAINDICATIONS

CONTRAINDICATIONS

- In the setting of renal insufficiency, tenofovir and lamivudine may require dose reduction or be contraindicated (refer to Appendix A of the original guideline document for additional information).

- Efavirenz should be avoided in pregnant women because it has been associated with teratogenicity in monkeys.
- Unboosted indinavir should not be used in pregnant women in the second and third trimester due to a substantial decrease in antepartum indinavir plasma concentrations.
- The combination of didanosine and stavudine should be avoided due to an increased risk of mitochondrial toxicity in pregnant women.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The AIDS Institute's Office of the Medical Director directly oversees the development, publication, dissemination and implementation of clinical practice guidelines, in collaboration with The Johns Hopkins University, Division of Infectious Diseases. These guidelines address the medical management of adults, adolescents and children with HIV infection; primary and secondary prevention in medical settings; and include informational brochures for care providers and the public.

Guidelines Dissemination

Guidelines are disseminated to clinicians, support service providers and consumers through mass mailings and numerous AIDS Institute-sponsored educational programs. Distribution methods include the HIV Clinical Resource website, the Clinical Education Initiative, the AIDS Educational Training Centers (AETC) and the HIV/AIDS Materials Initiative. Printed copies of clinical guidelines are available for order from the NYSDOH Distribution Center for providers who lack internet access.

Guidelines Implementation

The HIV Clinical Guidelines Program works with other programs in the AIDS Institute to promote adoption of guidelines. Clinicians, for example, are targeted through the Clinical Education Initiative (CEI) and the AETC. The CEI provides tailored educational programming on site for health care providers on important topics in HIV care, including those addressed by the HIV Clinical Guidelines Program. The AETC provides conferences, grand rounds and other programs that cover topics contained in AIDS Institute guidelines.

Support service providers are targeted through the HIV Education and Training initiative which provides training on important HIV topics to non-physician health and human services providers. Education is carried out across the State as well as through video conferencing and audio conferencing.

The HIV Clinical Guidelines Program also works in a coordinated manner with the HIV Quality of Care Program to promote implementation of HIV guidelines in New York State. By developing quality indicators based on the guidelines, the AIDS Institute has created a mechanism for measurement of performance that allows providers and consumers to know to what extent specific guidelines have been implemented.

Finally, best practices booklets are developed through the HIV Clinical Guidelines Program. These contain practical solutions to common problems related to access, delivery or coordination of care, in an effort to ensure that HIV guidelines are implemented and that patients receive the highest level of HIV care possible.

IMPLEMENTATION TOOLS

Clinical Algorithm
Personal Digital Assistant (PDA) Downloads
Pocket Guide/Reference Cards
Resources
Slide Presentation

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness
Timeliness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. HIV prophylaxis following non-occupational exposure including sexual assault. New York (NY): New York State Department of Health; 2008 Jan. 35 p. [31 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2005 Dec (revised 2008 Jan)

GUIDELINE DEVELOPER(S)

New York State Department of Health - State/Local Government Agency [U.S.]

SOURCE(S) OF FUNDING

New York State Department of Health

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Medical Care Criteria Committee

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: New York State Department of Health. HIV prophylaxis following non-occupational exposure including sexual assault. New York (NY): New York State Department of Health; 2005 Dec. 46 p.

GUIDELINE AVAILABILITY

Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Appendix A: antiretroviral drugs. New York (NY): New York State Department of Health; 2008 Jan. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.
- Appendix B: Rape Crisis Program. New York (NY): New York State Department of Health; 2008 Jan. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.
- Appendix C: Sexual Assault Forensic Examiner (SAFE) program. New York (NY): New York State Department of Health; 2008 Jan. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.
- Recommendations for HIV postexposure prophylaxis (PEP). Quick reference card. New York (NY): New York State Department of Health; 2004 Feb. 2 p. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.
- Non-occupational post-exposure prophylaxis (nPEP). Slide presentation. New York (NY): New York State Department of Health; 2005 Nov. Electronic copies: Available in Portable Document Format (PDF) from the New York State Department of Health AIDS Institute Web site.

This guideline is also available as a Personal Digital Assistant (PDA) download from the New York State Department of Health AIDS Institute Web site.

PATIENT RESOURCES

None available

NGC STATUS

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